Name_____ **Medicaid #**_____

THSteps-CCP Prior Authorization
Private Duty Nursing 4 or 6 month authorization

The following criteria must be met before seeking a 4 or 6 month authorization of PDN services. Remember that authorization is a condition for reimbursement; it is not a guarantee. Each nurse provider should verify the continued Medicaid coverage for each client for each month of service.

_____Client has received PDN services for at least one year.
_____Client has had no new significant diagnosis, treatment, illness/ injury or hospitalization in at least 6 months that would be expected to affect the need for PDN services.
_____There has been no change in the PDN requests in the previous 6 months.
_____Client's physician and primary care giver (parent) do not anticipate any significant changes in the client's condition for the requested authorization period.
_____The nurse provider will ensure that a new Physician Plan of Care is obtained every 60 days and will be maintained with the client's record.
_____The nurse provider will advise NHIC/CCP of any *significant* changes in the client's condition, treatments or physician orders which occur during the authorization period if the number of PDN hours needs to change.
_____The client's primary care giver, personal physician and nurse provider understand that the authorization may be changed during the authorization period if the client's condition or skilled needs change significantly.

All required acknowledgments must be signed and dated:

I have read and understand the above information.

_____ _____
(signature of **parent/primary care giver**) Date

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Brief statement of why a 4 or 6 month extension is appropriate for this client:

_____

I have discussed the above information with the client's parent/primary care giver.

_____ _____
(signature of the **nurse provider**) Date

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To be completed by the **client's physician**:
The above services are medically necessary, the client's condition is stable and this request supports the client's health and safety needs.

_____ _____
(signature of client's physician) Date

_____ _____
Printed name Telephone Number

_____ _____
Mailing address City, State Zip code Fax#

Fax completed request to NHIC/CCP at (512) 514-4212

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For NHIC/CCP use: Approved _____ Denied _____ Reviewer _____ Date _____